CSCT Work Group Committee
November 17, 2004

Members Present: Diane White, Jim Parker, Drew Eucher, Carol Ewen, Candy Lubansky, Bob Runkel, Susan Bailey-Anderson, Sara Loewen, Michelle Gillespie. Mike Kelly was present as a public observer.

Diane gave an overview of the Mental Health rules regarding the requirements of Mental Health Centers. This was done in reference to the question of whether a school could provide CSCT services without contracting through a MHC. She outlined the minimum standards that a Mental Health Center must meet. Diane was concerned about whether a school could meet the minimum requirements to become a MHC, and questioned whom the service would be geared.

When CSCT was started under Addictive and Mental Disorder Division the goal was to step SED youth down from higher levels of care back into a public school setting. Prior to CSCT being unbundled under AMDD administration, 72% of youth being served in CSCT had not received a prior authorized mental health service. CSCT was not intended to simply serve the most difficult to serve kids in school, but to step kids down from higher levels of mental health care, such as RTC. Despite the Special Education requirements of the public school system, some schools are very reluctant to provide services to emotionally disturbed youth once they have received mental health services outside the public school system. CSCT was modified from another mental health center service, day treatment. In an effort to provide services to ED and SED youth prior to placing them in a self-contained classroom, services to mainstream youth were provided. Day treatment program capacity off school grounds has increased, ie: Galen, Boulder and New Day example.

Bob commented that problems do exist with kids in a group home setting, who may not be attending public school. He stressed that all different kid-focused agencies need to develop a unified plan for those at risk students.

Drew and Carol pointed out that the intent of CSCT should be as a "step-down" program from more intense programs such as group homes and hospitals. Schools have been hesitant to take these kids because they were unsure of the availability of mental health services.

Drew agreed that it has been very helpful for schools to have control over the program. Originally the CSCT program became a "dumping ground" for students that they didn't know what else to do with. Now the schools have more control and say over the program. Students are "getting in" and "getting out" of the program, not being stuck there for years.

The issue of crisis calls for CSCT clients was discussed. Carol said that their on-call coverage was expensive and only used once in the last year and a half. She also said that they have had difficulty in getting their professional staff certified as mental health professionals. (Montana law limits the type of professional who can testify at an involuntary mental health commitment proceeding. Licensed mental health professionals must also become certified by the Additive and Mental Disorder Division to do this.) Schools would have difficulty employing these professionals.

Decision about whether schools can provide CSCT programs will have to be made, then we can go through and pick and choose the important elements of the program.

<u>Schools as CSCT Providers</u>

- Supervision of licensed clinical providers would come from whom if hired by the schools.
- Availability of providers willing to take on Medicaid clients.
    - Schools need to make connections with other providers to prescribe the needed psychotropic medications
    - Regular doctors don't have enough expertise or experience to prescribe these meds
        - It becomes a risk management issue

Drew stated that Great Falls wants no business dealing as a Mental Health Center. The question was asked if it is critical for the delivery of CSCT services to be provided by a MHC. Drew replied that it was for quality control and assurance of services.

The possibility of different requirements for a school to meet to become a "modified" Mental Health Center for the specific delivery of CSCT services was discussed. This was we could match services to the needs of the kids.

After much discussion, it was finally decided to keep Mental Health Centers as the CSCT provider. To think about to clarify in rule:

- Schools are responsible for services provided during school hours, no matter where the services are provided
- Mental Health Centers provide services outside the school setting
- Schools option of including CSCT service in IEP or not
- Redefine summer component of CSCT
    - Requirement of having school personnel on site or not
    - Option of school to continue CSCT program throughout summer

- Include in IEP
- Must child be in extended school year or allow in alternative settings

The group also discussed continuing to provide summer programming using CSCT school match funds. The group willl need to re-define the summer program requirements. Drew, Carol, and Jim will ask their staff for recommendations about how to define the summer program requirements. Doug Sullivan will also be asked to define what he would like to see in the future related to summer CSCT programs.

CSCT will continue to provide services to students in and outside of Special Education. Schools are not responsible for the non-federal match for students in Special Education if CSCT services are identified in the child's individual IEP.

Case management services provided by the CSCT provider were discussed. Prior to Addictive and Mental Disorder Division contracting for targeted youth case management services, a less intense level of case management existed, called "care coordination". Care coordination was limited to 4 hours a month. CSCT providers have provided a care coordination level of case management and would like to see the CSCT administrative rules changed accordingly.
The group felt care coordination better defines what schools and mental health centers provide to children in the CSCT program.

The "12 child" CSCT maximum caseload and 2 transitioning out of CSCT outpatient limit was discussed. If we expand the caseload, it may be interpreted as "making a profit". The idea of changing the "twelve child limit" to 960 units per 30 days (80 units maximum x 12 children), with no definite number of children to be served with these units was brought up. Instead of using the maximum of 80 units, it was suggested that we use 720 units per 30 days (60 units x 12) to avoid problems with over-utilization. The question of whether each program within each school would need their own provider number, or have a "pool" of the number of approved programs for the district x 720 units. Michelle stated she would need to look into the feasibility of this change with MMIS. Everyone present agreed that this could be a workable solution to the "12 child" limit problem. With this proposed change, should a caseload limit on the number of CSCT clients be added? Could a CSCT program provide just the outpatient therapy and community based psychiatric rehabilitation and support services? Would this discourage a school from providing CSCT services to tough to serve kids stepping down from higher levels of mental health care?

Drew will send another example of best practice for group to review at the next meeting. Carol will share what training requirements regarding behavioral assessments they use as well as how they assure these are implemented.

Brief discussion of best practice - schools oversee program, mental health centers describe fidelity of the CSCT program. Are interventions research proven. Schools can oversee the services provided by the mental health center in which they contract. This allows a measure of supervision of schools with the mental health center. Teachers are the best people to teach behavior, they would know first-hand if the treatment a child is receiving is effective.

The next meeting is scheduled for December 20, 2004 from 1:00 – 4:00 in the Sanders building, Room 207.